CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
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BOARD OF EXAMINERS IN OPTOMETRY

OPTOMETRY INTERNSHIP
STATEMENT OF SUPERVISING DOCTOR

An internship pre-approved by the Delaware Board of Examiners in Optometry is a requirement for licensure in Delaware. The Board requires the statement as part of the approval process. Each doctor who will be supervising the intern must complete and submit one of these statements. Note that the statement must be signed and notarized.

Under Delaware rules and regulations, an internship must be at least six months in duration, and the intern must work at least 35 hours per week.

The internship must be under the supervision of a licensed optometrist or ophthalmologist. If the supervising doctor is an optometrist who is neither therapeutically certified in Delaware nor in a state where the therapeutic standards are comparable to those of Delaware, the intern will be required to complete an additional 100 hours of clinical internship. This 100 hours must be under the supervision of a medical doctor, osteopathic physician or an optometrist who is therapeutically certified in Delaware or in a state with therapeutic standards comparable to those of Delaware.

Each supervising doctor is permitted to supervise only one intern at a time. The supervising doctor must:

- Supervise the intern one-on-one
- Be on the same premises and immediately available to the intern at all times
- Review the intern's patient evaluations before the patient leaves the office

These are examples of situations, which are not direct supervision as required by the rules and regulations:

- A supervising doctor has two offices, and he/she works in office 1 and the intern works in office 2.
- Three doctors work in the supervising doctor's office. When the supervisor leaves, he/she assigns another doctor to supervise the intern. This is acceptable only if the doctor supervising the intern is also approved by the Board and is not supervising another intern.

When the internship is complete, each supervising doctor must send a letter to the Board verifying the completion of the internship.

OPTOMETRY INTERNSHIP
STATEMENT OF SUPERVISING DOCTOR

1. Intern's name: _____

2. Your name: _____

3. Your address: _____

_____

4. Phone number: _____Email: _____

5. Are you licensed as an optometrist, osteopathic physician or medical doctor? Yes ____ No ____

6. If you are an optometrist, are you therapeutically certified in any State in which you are licensed? Yes ____ No ____ If Yes, list all State(s) in which you are therapeutically certified: _____

7. Will other optometrists, osteopathic physicians, or medical doctors in your practice supervise the above intern at any time? Yes ____ No ____ If yes; please list their names below: _____

Each supervising doctor must complete a "Statement of Supervising Doctor."

8. Does your practice have an intern other than the intern names above? Yes ____ No ____

9. Will the internship last at least 6 months from the date of Board approval? Yes ____ No ____

10. How many hours per week will the intern work? _____ Hours

11. How many hours per week will you personally supervise the intern? _____ hours

12. What will be the intern's duties? _____

13. What are the goals of the internship? _____

_____

I certify that the information in this statement is complete and true.

YOUR SIGNATURE: _____ DATE: _____

Sworn to and subscribed to me before this _____day of _____ in the year _____

NOTARY PUBLIC _____ AFFIX SEAL

My commission expires: _____

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CERTIFICATION OF OPTOMETRY LICENSURE

Instructions to Applicant: Send a copy of this form to each State in which you are now, or have been, licensed to practice optometry. Note that states may require a fee for this service.

TO BE COMPLETED BY APPLICANT:

NAME: _____

ADDRESS: _____

_____

LICENSE NUMBER: _____ STATE: _____

TO BE COMPLETED BY STATE BOARD:
Please verify the licensure of the above Optometrist by providing the following information:

License Number: _____Date Issued: _____ Expiration Date: _____

Is Optometrist Therapeutically Certified? Yes___No____ If yes, date: _____

Has this individual's license ever been suspended or revoked or other disciplinary action taken? Yes _____No _____ If yes, please attach documentation.

Are any disciplinary proceedings or unresolved complaints pending against this Optometrist? Yes _____ No_____ If yes, please attach documentation.

The Board of _____of the State of _____

Certifies that the above information is correct.

Signature: _____

Title: _____

(Seal)